State of Arizona
Senate
Forty-seventh Legislature
First Regular Session
2005

CHAPTER 193

SENATE BILL 1137

AN ACT

AMENDING SECTIONS 36-2903, 36-2907 AND 36-3408, ARIZONA REVISED STATUTES; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 36-2903, Arizona Revised Statutes, is amended to read:

36-2903. Arizona health care cost containment system; administrator; powers and duties of director and administrator; exemption from attorney general representation; definition

A. The Arizona health care cost containment system is established consisting of contracts with contractors for the provision of hospitalization and medical care coverage to members. Except as specifically required by federal law and by section 36-2909, the system is only responsible for providing care on or after the date that the person has been determined eligible for the system, and is only responsible for reimbursing the cost of care rendered on or after the date that the person was determined eligible for the system.

B. An agreement may be entered into with an independent contractor, subject to title 41, chapter 23, to serve as the statewide administrator of the system. The administrator has full operational responsibility, subject to supervision by the director, for the system, which may include any or all of the following:

1. Development of county-by-county implementation and operation plans for the system that include reasonable access to hospitalization and medical care services for members.

2. Contract administration~~, certification~~ and oversight of contractors, INCLUDING CERTIFICATION INSTEAD OF LICENSURE FOR TITLE XVIII AND TITLE XIX PURPOSES.

3. Provision of technical assistance services to contractors and potential contractors.

4. Development of a complete system of accounts and controls for the system including provisions designed to ensure that covered health and medical services provided through the system are not used unnecessarily or unreasonably including but not limited to inpatient behavioral health services provided in a hospital. Periodically the administrator shall compare the scope, utilization rates, utilization control methods and unit prices of major health and medical services provided in this state in comparison with other states' health care services to identify any unnecessary or unreasonable utilization within the system. The administrator shall periodically assess the cost effectiveness and health implications of alternate approaches to the provision of covered health and medical services through the system in order to reduce unnecessary or unreasonable utilization.

5. Establishment of peer review and utilization review functions for all contractors.

6. Assistance in the formation of medical care consortiums to provide covered health and medical services under the system for a county.

7. Development and management of a contractor payment system.

8. Establishment and management of a comprehensive system for assuring the quality of care delivered by the system.

9. Establishment and management of a system to prevent fraud by members, subcontracted providers of care, contractors and noncontracting providers.

10. Coordination of benefits provided under this article to any member. The administrator may require that contractors and noncontracting providers are responsible for the coordination of benefits for services provided under this article. Requirements for coordination of benefits by noncontracting providers under this section are limited to coordination with standard health insurance and disability insurance policies and similar programs for health coverage.

11. Development of a health education and information program.

12. Development and management of an enrollment system.

13. Establishment and maintenance of a claims resolution procedure to ensure that ninety per cent of the clean claims shall be paid within thirty days of receipt and ninety-nine per cent of the remaining clean claims shall be paid within ninety days of receipt. For the ~~purpose~~ PURPOSES of this paragraph, "clean claims" has the same meaning as prescribed in section 36-2904, subsection G.

14. Establishment of standards for the coordination of medical care and patient transfers pursuant to section 36-2909, subsection B.

15. Establishment of a system to implement medical child support requirements, as required by federal law. The administration may enter into an intergovernmental agreement with the department of economic security to implement ~~the provisions of~~ this paragraph.

16. Establishment of an employee recognition fund.

17. ESTABLISHMENT OF AN ELIGIBILITY PROCESS TO DETERMINE WHETHER A MEDICARE LOW INCOME SUBSIDY IS AVAILABLE TO PERSONS WHO WANT TO APPLY FOR A SUBSIDY AS AUTHORIZED BY TITLE XVIII.

C. If an agreement is not entered into with an independent contractor to serve as statewide administrator of the system pursuant to subsection B of this section, the director shall ensure that the operational responsibilities set forth in subsection B of this section are fulfilled by the administration and other contractors as necessary.

D. If the director determines that the administrator will fulfill some but not all of the responsibilities set forth in subsection B of this section, the director shall ensure that the remaining responsibilities are fulfilled by the administration and other contractors as necessary.

E. The administrator or any direct or indirect subsidiary of the administrator is not eligible to serve as a contractor.

F. Except for reinsurance obtained by contractors, the administrator shall coordinate benefits provided under this article to any eligible person who is covered by workers' compensation, disability insurance, a hospital and

medical service corporation, a health care services organization, an accountable health plan or any other health or medical or disability insurance plan including coverage made available to persons defined as eligible by section 36-2901, paragraph 6, subdivisions (b), (c), (d) and (e), or who receives payments for accident-related injuries, so that any costs for hospitalization and medical care paid by the system are recovered from any other available third party payors. The administrator may require that contractors and noncontracting providers are responsible for the coordination of benefits for services provided under this article. Requirements for coordination of benefits by noncontracting providers under this section are limited to coordination with standard health insurance and disability insurance policies and similar programs for health coverage. The system shall act as payor of last resort for persons eligible pursuant to section 36-2901, paragraph 6, subdivision (a), section 36-2974 or section 36-2981, paragraph 6 unless specifically prohibited by federal law. By operation of law, eligible persons assign to the system and a county rights to all types of medical benefits to which the person is entitled, including first party medical benefits under automobile insurance policies based on the order of priorities established pursuant to section 36-2915. The state has a right to subrogation against any other person or firm to enforce the assignment of medical benefits. The provisions of this subsection are controlling over the provisions of any insurance policy that provides benefits to an eligible person if the policy is inconsistent with the provisions of this subsection.

G. Notwithstanding subsection E of this section, the administrator may subcontract distinct administrative functions to one or more persons who may be contractors within the system.

H. The director shall require as a condition of a contract with any contractor that all records relating to contract compliance are available for inspection by the administrator and the director subject to subsection I of this section and that such records be maintained by the contractor for five years. The director shall also require that these records be made available by a contractor on request of the secretary of the United States department of health and human services, or its successor agency.

I. Subject to existing law relating to privilege and protection, the director shall prescribe by rule the types of information that are confidential and circumstances under which such information may be used or released, including requirements for physician-patient confidentiality. Notwithstanding any other provision of law, such rules shall be designed to provide for the exchange of necessary information among the counties, the administration and the department of economic security for the purposes of eligibility determination under this article. Notwithstanding any law to the contrary, a member's medical record shall be released without the member's consent in situations or suspected cases of fraud or abuse relating to the system to an officer of the state's certified Arizona health care cost

containment system fraud control unit who has submitted a written request for the medical record.

J. The director shall prescribe rules that specify methods for:

1. The transition of members between system contractors and noncontracting providers.

2. The transfer of members and persons who have been determined eligible from hospitals that do not have contracts to care for such persons.

K. The director shall adopt rules that set forth procedures and standards for use by the system in requesting county long-term care for members or persons determined eligible.

L. To the extent that services are furnished pursuant to this article, and unless otherwise required pursuant to this chapter, a contractor is not subject to the provisions of title 20.

M. As a condition of the contract with any contractor, the director shall require contract terms as necessary in the judgment of the director to ensure adequate performance and compliance with all applicable federal laws by the contractor of the provisions of each contract executed pursuant to this chapter. Contract provisions required by the director shall include at a minimum the maintenance of deposits, performance bonds, financial reserves or other financial security. The director may waive requirements for the posting of bonds or security for contractors that have posted other security, equal to or greater than that required by the system, with a state agency for the performance of health service contracts if funds would be available from such security for the system on default by the contractor. The director may also adopt rules for the withholding or forfeiture of payments to be made to a contractor by the system for the failure of the contractor to comply with a provision of the contractor's contract with the system or with the adopted rules. The director may also require contract terms allowing the administration to operate a contractor directly under circumstances specified in the contract. The administration shall operate the contractor only as long as it is necessary to assure delivery of uninterrupted care to members enrolled with the contractor and accomplish the orderly transition of those members to other system contractors, or until the contractor reorganizes or otherwise corrects the contract performance failure. The administration shall not operate a contractor unless, before that action, the administration delivers notice to the contractor and provides an opportunity for a hearing in accordance with procedures established by the director. Notwithstanding the provisions of a contract, if the administration finds that the public health, safety or welfare requires emergency action, it may operate as the contractor on notice to the contractor and pending an administrative hearing, which it shall promptly institute.

N. The administration for the sole purpose of matters concerning and directly related to the Arizona health care cost containment system and the Arizona long-term care system is exempt from section 41-192.

O. Notwithstanding subsection F of this section, if the administration determines that according to federal guidelines it is more cost-effective for a person defined as eligible under section 36-2901, paragraph 6, subdivision (a) to be enrolled in a group health insurance plan in which the person is entitled to be enrolled, the administration may pay all of that person's premiums, deductibles, coinsurance and other cost sharing obligations for services covered under section 36-2907. The person shall apply for enrollment in the group health insurance plan as a condition of eligibility under section 36-2901, paragraph 6, subdivision (a).

P. The total amount of state monies that may be spent in any fiscal year by the administration for health care shall not exceed the amount appropriated or authorized by section 35-173 for all health care purposes. This article does not impose a duty on an officer, agent or employee of this state to discharge a responsibility or to create any right in a person or group if the discharge or right would require an expenditure of state monies in excess of the expenditure authorized by legislative appropriation for that specific purpose.

Q. Notwithstanding section 36-470, a contractor or program contractor may receive laboratory tests from a laboratory or hospital-based laboratory for a system member enrolled with the contractor or program contractor subject to all of the following requirements:

1. The contractor or program contractor shall provide a written request to the laboratory in a format mutually agreed to by the laboratory and the requesting health plan or program contractor. The request shall include the member's name, the member's plan identification number, the specific test results that are being requested and the time periods and the quality improvement activity that prompted the request.

2. The laboratory data may be provided in written or electronic format based on the agreement between the laboratory and the contractor or program contractor. If there is no contract between the laboratory and the contractor or program contractor, the laboratory shall provide the requested data in a format agreed to by the noncontracted laboratory.

3. The laboratory test results provided to the member's contractor or program contractor shall only be used for quality improvement activities authorized by the administration and health care outcome studies required by the administration. The contractors and program contractors shall maintain strict confidentiality about the test results and identity of the member as specified in contractual arrangements with the administration and pursuant to state and federal law.

4. The administration, after collaboration with the department of health services regarding quality improvement activities, may prohibit the contractors and program contractors from receiving certain test results if the administration determines that a serious potential exists that the results may be used for purposes other than those intended for the quality improvement activities. The department of health services shall consult with

the clinical laboratory licensure advisory committee established by section 36-465 before providing recommendations to the administration on certain test results and quality improvement activities.

5. The administration shall provide contracted laboratories and the department of health services with an annual report listing the quality improvement activities that will require laboratory data. The report shall be updated and distributed to the contracting laboratories and the department of health services when laboratory data is needed for new quality improvement activities.

6. A laboratory that complies with a request from the contractor or program contractor for laboratory results pursuant to this section is not subject to civil liability for providing the data to the contractor or program contractor. The administration, the contractor or a program contractor that uses data for reasons other than quality improvement activities is subject to civil liability for this improper use.

R. For the ~~purpose~~ PURPOSES of this section, "quality improvement activities" means those requirements, including health care outcome studies specified in federal law or required by the centers for medicare and medicaid services or the administration, to improve health care outcomes.

Sec. 2. Section 36-2907, Arizona Revised Statutes, is amended to read:

36-2907. Covered health and medical services; modifications; related delivery of service requirements

A. Unless modified pursuant to this section, contractors shall provide the following medically necessary health and medical services:

1. Inpatient hospital services that are ordinarily furnished by a hospital for the care and treatment of inpatients and that are provided under the direction of a physician or a primary care practitioner. For the purposes of this section, ~~"~~inpatient hospital services~~"~~ excludes services in an institution for tuberculosis or mental diseases unless authorized under an approved section 1115 waiver.

2. Outpatient health services that are ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. Outpatient health services include services provided by or under the direction of a physician or a primary care practitioner but do not include occupational therapy, or speech therapy for eligible persons who are twenty-one years of age or older.

3. Other laboratory and x-ray services ordered by a physician or a primary care practitioner.

4. Medications that are ordered on prescription by a physician or a dentist licensed pursuant to title 32, chapter 11. BEGINNING JANUARY 1, 2006, PERSONS WHO ARE DUALLY ELIGIBLE FOR TITLE XVIII AND TITLE XIX SERVICES MUST OBTAIN AVAILABLE MEDICATIONS THROUGH A MEDICARE LICENSED OR CERTIFIED MEDICARE ADVANTAGE PRESCRIPTION DRUG PLAN, A MEDICARE PRESCRIPTION DRUG PLAN OR ANY OTHER ENTITY AUTHORIZED BY MEDICARE TO PROVIDE A MEDICARE PART D PRESCRIPTION DRUG BENEFIT.

5. Emergency dental care and extractions for persons who are at least twenty-one years of age.

6. Medical supplies, equipment and prosthetic devices, not including hearing aids, ordered by a physician or a primary care practitioner or dentures ordered by a dentist licensed pursuant to title 32, chapter 11. Suppliers of durable medical equipment shall provide the administration with complete information about the identity of each person who has an ownership or controlling interest in their business and shall comply with federal bonding requirements in a manner prescribed by the administration.

7. For persons who are at least twenty-one years of age, treatment of medical conditions of the eye excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses.

8. Early and periodic health screening and diagnostic services as required by section 1905(r) of title XIX of the social security act for members who are under twenty-one years of age.

9. Family planning services that do not include abortion or abortion counseling. If a contractor elects not to provide family planning services, this election does not disqualify the contractor from delivering all other covered health and medical services under this chapter. In that event, the administration may contract directly with another contractor, including an outpatient surgical center or a noncontracting provider, to deliver family planning services to a member who is enrolled with the contractor that elects not to provide family planning services.

10. Podiatry services performed by a podiatrist licensed pursuant to title 32, chapter 7 and ordered by a primary care physician or primary care practitioner.

11. Nonexperimental transplants approved for title XIX reimbursement.

12. Ambulance and nonambulance transportation.

B. Beginning on October 1, 2002, circumcision of newborn males is not a covered health and medical service.

C. The system shall pay noncontracting providers only for health and medical services as prescribed in subsection A of this section and as prescribed by rule.

D. The director shall adopt rules necessary to limit, to the extent possible, the scope, duration and amount of services, including maximum limitations for inpatient services that are consistent with federal regulations under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)). To the extent possible and practicable, these rules shall provide for the prior approval of medically necessary services provided pursuant to this chapter.

E. The director shall make available home health services in lieu of hospitalization pursuant to contracts awarded under this article. For the purposes of this subsection, "home health services" means the provision of nursing services, home health aide services or medical supplies, equipment and appliances, which are provided on a part-time or intermittent basis by a

licensed home health agency within a member's residence based on the orders of a physician or a primary care practitioner. Home health agencies shall comply with the federal bonding requirements in a manner prescribed by the administration.

F. The director shall adopt rules for the coverage of behavioral health services for persons who are eligible under section 36-2901, paragraph 6, subdivision (a). The administration shall contract with the department of health services for the delivery of all medically necessary behavioral health services to persons who are eligible under rules adopted pursuant to this subsection. The division of behavioral health in the department of health services shall establish a diagnostic and evaluation program to which other state agencies shall refer children who are not already enrolled pursuant to this chapter and who may be in need of behavioral health services. In addition to an evaluation, the division of behavioral health shall also identify children who may be eligible under section 36-2901, paragraph 6, subdivision (a) or section 36-2931, paragraph 5 and shall refer the children to the appropriate agency responsible for making the final eligibility determination.

G. The director shall adopt rules for the provision of transportation services and rules providing for copayment by members for transportation for other than emergency purposes. Prior authorization is not required for medically necessary ambulance transportation services rendered to members or eligible persons initiated by dialing telephone number 911 or other designated emergency response systems.

H. The director may adopt rules to allow the administration, at the director's discretion, to use a second opinion procedure under which surgery may not be eligible for coverage pursuant to this chapter without documentation as to need by at least two physicians or primary care practitioners.

I. If the director does not receive bids within the amounts budgeted or if at any time the amount remaining in the Arizona health care cost containment system fund is insufficient to pay for full contract services for the remainder of the contract term, the administration, on notification to system contractors at least thirty days in advance, may modify the list of services required under subsection A of this section for persons defined as eligible other than those persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). The director may also suspend services or may limit categories of expense for services defined as optional pursuant to title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) for persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). Such reductions or suspensions do not apply to the continuity of care for persons already receiving these services.

J. Additional, reduced or modified hospitalization and medical care benefits may be provided under the system to enrolled members who are

eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

K. All health and medical services provided under this article shall be provided in the geographic service area of the member, except:

1. Emergency services and specialty services provided pursuant to section 36-2908.

2. That the director may permit the delivery of health and medical services in other than the geographic service area in this state or in an adjoining state if the director determines that medical practice patterns justify the delivery of services or a net reduction in transportation costs can reasonably be expected. Notwithstanding the definition of physician as prescribed in section 36-2901, if services are procured from a physician or primary care practitioner in an adjoining state, the physician or primary care practitioner shall be licensed to practice in that state pursuant to licensing statutes in that state similar to title 32, chapter 13, 15, 17 or 25 and shall complete a provider agreement for this state.

L. Covered outpatient services shall be subcontracted by a primary care physician or primary care practitioner to other licensed health care providers to the extent practicable for purposes including, but not limited to, making health care services available to underserved areas, reducing costs of providing medical care and reducing transportation costs.

M. The director shall adopt rules that prescribe the coordination of medical care for persons who are eligible for system services. The rules shall include provisions for the transfer of patients, the transfer of medical records and the initiation of medical care.

Sec. 3. Section 36-3408, Arizona Revised Statutes, is amended to read:

36-3408. Eligibility for behavioral health service system; screening process; required information

A. Any person who requests behavioral health services pursuant to this chapter or the person's parent or legal guardian shall comply with a preliminary financial screening and eligibility process developed by the department of health services in coordination with the Arizona health care cost containment system administration and administered at the initial intake level. A person who receives behavioral health services pursuant to this chapter and who has not been determined eligible for TITLE XVIII AND FOR THE MEDICARE PART D PRESCRIPTION DRUG BENEFIT, title XIX or title XXI services shall comply annually with the eligibility determination process. If the results indicate that the person may be ELIGIBLE FOR TITLE XVIII AND FOR THE MEDICARE PART D PRESCRIPTION DRUG BENEFIT, title XIX ~~eligible~~ OR TITLE XXI, in order to continue to receive services pursuant to this chapter, the applicant shall submit a completed application within ten working days to the social security administration, the department of economic security or the Arizona health care cost containment system administration, which shall determine the applicant's eligibility pursuant to TITLE XVIII AND FOR THE MEDICARE PART D PRESCRIPTION DRUG BENEFIT, section 36-2901, paragraph 6,

subdivision (a), section 36-2931, paragraph 5 or section 36-2981, paragraph 6 for health and medical or long-term care services PURSUANT TO CHAPTER 29 OF THIS TITLE. The applicant shall cooperate fully with the eligibility determination process. If the person is in need of emergency services provided pursuant to this chapter, the person may begin to receive these services immediately provided that within five days from the date of service a financial screening is initiated.

B. Applicants who refuse to cooperate in the financial screening and eligibility process are not eligible for services pursuant to this chapter. A form explaining loss of benefits due to refusal to cooperate shall be signed by the applicant. Refusal to cooperate shall not be construed to mean the applicant's inability to obtain documentation required for eligibility determination. The department of economic security and the Arizona health care cost containment system administration shall promptly inform the department of health services of the applications that are denied based on an applicant's failure to cooperate with the eligibility determination process and, on request, of applicants who do not submit an application as required by this section.

C. The department of economic security, in coordination with the department of health services, shall provide on-site eligibility determinations at appropriate program locations subject to legislative appropriation.

D. This section only applies to persons who receive services that are provided pursuant to this section and that are paid for in whole or in part with state funds.

E. A person who requests treatment services under this chapter shall provide personally identifying information required by the department of health services.

F. Except as otherwise provided by law, this section and cooperation with the eligibility determination process do not entitle any person to any particular services that are subject to legislative appropriation.

Sec. 4. Emergency

This act is an emergency measure that is necessary to preserve the public peace, health or safety and is operative immediately as provided by law.

APPROVED BY THE GOVERNOR APRIL 25, 2005.

FILED IN THE OFFICE OF THE SECRETARY OF STATE APRIL 25, 2005.

Passed the House April 11, 2005,

by the following vote: 56 Ayes,

2 Nays, 2 Not Voting

with Emergency

Speaker of the House

Norman L. Moore

Chief Clerk of the House

Passed the Senate March 1, 2005,

by the following vote: 26 Ayes,

0 Nays, 4 Not Voting

with Emergency

President of the Senate

Secretary of the Senate

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF GOVERNOR
This Bill was received by the Governor this

_____ day of _____, 20____,

at _____ o'clock _____ M.

Secretary to the Governor

Approved this _____ day of

_____, 20_____,

at _____ o'clock _____ M.

Governor of Arizona

EXECUTIVE DEPARTMENT OF ARIZONA
OFFICE OF SECRETARY OF STATE

This Bill was received by the Secretary of State

this _____ day of _____, 20____,

at _____ o'clock _____ M.

Secretary of State

S.B. 1137

SENATE CONCURS IN HOUSE AMENDMENTS AND FINAL PASSAGE

Passed the Senate April 18, 2005,

by the following vote: 29 Ayes,

0 Nays, 1 Not Voting with Emergency

President of the Senate

Secretary of the Senate

EXECUTIVE DEPARTMENT OF ARIZONA OFFICE OF GOVERNOR

This Bill was received by the Governor this

19th day of April, 2005

at 8:05 o'clock a. M.

Secretary to the Governor

Approved this 25 day of

April, 2005,

at 9:45 o'clock A. M.

Governor of Arizona

EXECUTIVE DEPARTMENT OF ARIZONA OFFICE OF SECRETARY OF STATE

This Bill was received by the Secretary of State

this 25 day of April, 2005,

at 4:33 o'clock P. M.

Janice K. Brewer

Secretary of State

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